Medicaid and CHIP in the Territories

Medicaid and the State Children's Health Insurance Program (CHIP) operate in the five U.S. territories—American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands. This fact sheet summarizes federal requirements and design features of these programs in the territories, including eligibility and enrollment, benefits, financing and spending, data and reporting, and quality and program integrity. For more details on each territory's individual program, see MACPAC's territory-specific fact sheets.

Individuals born in the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands are U.S. citizens, and those born in American Samoa are U.S. nationals.[1] Their eligibility for federally subsidized programs varies by territory and program. For example, residents of all five territories may participate in Medicaid, CHIP, Medicare, and Social Security, but none except for the Northern Mariana Islands are eligible for Supplemental Security Income (SSI) (Committee on Ways and Means 2014).

Under the Social Security Act (the Act) the territories are considered states for the purposes of Medicaid and CHIP, unless otherwise indicated (§1101(a)(1) of the Act). However, their programs differ in many respects from those in the 50 states and the District of Columbia. The most notable difference is that rather than having an open-ended financing structure, Medicaid in the territories operates with an annual ceiling on federal financial participation (§1108(g) of the Act). The federal government matches territory dollars up to the specified Medicaid ceiling, and beyond that, the territories generally must fund their programs with local funds. Because Medicaid still operates as an entitlement with benefits guaranteed to all eligible individuals who apply, territories historically have exceeded their annual ceilings (MACPAC 2016).

Two territories, the Northern Mariana Islands and American Samoa, operate their Medicaid and CHIP programs under a Section 1902(j) waiver that is uniquely available to them (§1902(j) of the Act). This provision allows the Secretary of the U.S. Department of Health and Human Services (the Secretary) to waive or modify any Medicaid requirement except for the statutory annual limit on federal Medicaid funding, the federal medical assistance percentage (FMAP), and the requirement that payment can only be for services otherwise coverable by Medicaid. For example, while neither of these territories provides all of Medicaid's mandatory benefits, they are considered in compliance with federal Medicaid law.

Eligibility and Enrollment

All five territories are permitted to establish income-based eligibility using a measure other than the federal poverty level (FPL). Guam, Puerto Rico, and the U.S. Virgin Islands use local poverty levels to establish eligibility, which are updated by amendment to the Medicaid state plan. These three territories are also statutorily exempt from providing Medicaid coverage to certain mandatory coverage groups including

poverty-related children and pregnant women and qualified Medicare beneficiaries (§§1902(l)(4)(B) and 1905(p)(4)(A) of the Act). American Samoa and the Northern Mariana Islands are also exempt from these requirements under their 1902(j) waivers.

American Samoa and the Northern Mariana Islands use unique methods to establish income-based eligibility. In American Samoa, Medicaid eligibility is not determined on an individual basis and individuals do not enroll in Medicaid or CHIP like in all other territories and states. Instead, federal Medicaid and CHIP funds pay for care provided at the Lyndon B. Johnson Tropical Medical Center in proportion to the population of American Samoans with income that would have fallen below Medicaid and CHIP income eligibility threshold of 200 percent FPL (CMS 2014). The Northern Mariana Islands, the only territory participating in SSI, uses SSI income and asset standards to determine Medicaid eligibility (CMS 2016a).

Guam, Puerto Rico, and the U.S. Virgin Islands have elected to expand their Medicaid programs to the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) up to 133 percent of local poverty (CMS 2016a).

All five territories operate Medicaid-expansion CHIP programs (CMS 2015). Puerto Rico is the only territory that uses its CHIP funds to cover additional children whose income levels exceed regular Medicaid eligibility levels. The other four territories use their CHIP funds to pay for services provided to children under age 19 in their Medicaid programs and can access the CHIP enhanced match for these individuals (CMS 2016a).

Territories vary widely in the percentage of their populations covered by Medicaid or CHIP due to differences in eligibility standards and methodologies, as well as differences in the economic conditions for the territories (Table 1).

TABLE 1: Medicaid and CHIP Enrollment as a Share of the Population, 2015

Territory	Number of enrollees	Percentage of population enrolled in Medicaid or CHIP
American Samoa	40,515[1]	75%
Guam	38,482	24
Northern Mariana Islands	19,076	36
Puerto Rico	1,671,657	46
U.S. Virgin Islands	18,036	17

Notes: Enrollment figures as of January 2015 for American Samoa, Guam, and the Northern Mariana Islands, June 2015 for Puerto Rico, and July 2015 for the U.S. Virgin Islands.
[1]Enrollment figures for American Samoa are estimates of the portion of the population below 200 percent FPL, the population for which Medicaid pays for health care services. American Samoa does not make individual eligibility determinations and does not have an enrolled population.
Sources: CMS 2016a, MACPAC analysis of population data from the Central Intelligence Agency *World Factbook* as of July 2015.

Benefits

Covered benefits

Medicaid benefits vary across territories. American Samoa and the Northern Mariana Islands are not required to offer mandatory Medicaid benefits under their Section 1902(j) waivers. Guam, Puerto Rico, and the U.S. Virgin Islands are required to offer all mandatory benefits, but currently Guam is the only territory to do so. For example, the U.S. Virgin Islands does not cover freestanding birth center or rural health clinic services. Puerto Rico does not cover non-emergency medical transportation or nursing facility services, citing lack of infrastructure and funding (GAO 2016). All territories provide some optional benefits. For example, all territories cover prescription drugs, clinic services, dental services, and eyeglasses. Additionally, in all territories, individuals under age 21 are eligible to receive Early and Periodic Screening, Diagnostic, and Treatment services (GAO 2016, CMS 2016e). [2,3]

Delivery system

Puerto Rico is currently the only territory to use Medicaid managed care, in which the entire Medicaid population is enrolled. The Medicaid programs in the other four territories operate on a fee-for-service basis. Additionally, in American Samoa, Guam, and the Northern Mariana Islands, almost all Medicaid services are provided by one territory-owned-and-operated hospital (CMS 2016a).[4]

Benefits for dually eligible beneficiaries

All five territories' Medicaid programs offer some form of cost-sharing assistance for Medicare enrollees who are also eligible for full Medicaid benefits (CMS 2016b). None of them offer cost sharing assistance to individuals who may qualify as partial dually eligible individuals through Medicare Savings Programs in the states because these programs are not available in the territories.[5] Medicaid programs in American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands pay Medicare Part B premiums for dually eligible individuals (CMS 2014d). Puerto Rico pays premiums and cost sharing for Medicare Platino plans, a type of Medicare Advantage special needs plan that includes Medicare Part A and B services as well as outpatient prescription drugs. Almost all dually eligible Puerto Ricans are enrolled in Medicare Platino (HHS 2013).

No Medicare Part D plans are available in the territories, but territory Medicaid programs typically provide prescription drugs to dually eligible beneficiaries. To offset the cost of doing so, territories each receive an additional allotment from the Enhanced Allotment Plan, also referred to as 1935(e) funding. This allotment is not countable toward the ceiling on federal financial participation and can only be used to help pay for prescription drugs for low-income beneficiaries (§1935(e) of the Act).[6]

Financing and Spending

The federal government and territorial governments jointly finance the territories' Medicaid programs. Each territory must contribute its non-federal share of Medicaid spending in order to access federal dollars,

which are matched at the designated FMAP, or matching rate. Unlike the states and the District of Columbia, for which federal Medicaid spending is open ended, the territories can only access federal dollars up to an annual ceiling. The ceiling and matching rate are described in more detail below.

Federal funding

Federal Medicaid funding to Puerto Rico is subject to an annual funding ceiling specified in statute, which grows with the medical component of the Consumer Price Index for All Urban Consumers (CPI-U) (§1108(g)). Each territory's CHIP allotment is determined by the Centers for Medicare & Medicaid Services (CMS) based on prior year spending, the same methodology used for states.

In general, once a territory exhausts its annual federal Medicaid and CHIP ceilings, it must fund its program with local funds. However, Congress has temporarily provided additional federal Medicaid funds on a temporary basis to the territories on multiple occasions. For example, the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) raised each territory's annual Medicaid ceiling by 30 percent for the period between October 1, 2009 and June 30, 2011 (§5001(d) of ARRA).

The ACA also provided the territories with additional federal funding for their Medicaid programs. Section 2005 provided total of $6.3 billion in additional federal funds for the territories, to be allocated by the Secretary and available to be drawn down between July 2011 and September 2019. Section 1323 provided an additional $1 billion to the territories, $925 million of which was directed to Puerto Rico and the remainder of which was allocated by the Secretary.[7] These funds are available to be drawn down between July 2011 and December 2019, but only after a territory has exhausted its funds under Section 2005 (CMS 2016a). Total additional funding for each territory ranged from $198 million to $6.3 billion (Table 2). Each territory must contribute a non-federal share to access these funds.

Congress has not made available any additional funds for the territories beyond those provided by the ACA. Once the ACA funds expire or are exhausted, territories will generally not be able to spend federal dollars beyond their respective ceilings for Medicaid and CHIP.[8]

Federal medical assistance percentage

The FMAP for the territories is statutorily set at 55 percent, unlike those for states which are set using a formula based on states' per capita incomes (§1905(b) of the Act). The territories' CHIP enhanced FMAP is 91.5 percent (§2101(a) of the ACA; MACPAC 2015a). Like the states, the territories' federal matching rate for almost all program administration is set at 50 percent (§1903(a)(7) of the Act).

The territories cannot claim the 100 percent FMAP available for states expanding to the new adult group but were eligible for a temporary 2.2 percentage point increase in their regular FMAP, which applied to all state plan populations (CMS 2016b). This increase raised territories' FMAPs to 57.2 percent for the period between January 1, 2014 and December 31, 2015 (§§1905(y)(1) and 1905(z)(1)(A) of the Act). Additionally, territories are eligible for the expansion state enhanced FMAP for adults without dependent children that states were eligible to receive for expansions prior to the ACA (§1905(z) of the Act).

Non-federal share

The territories fund the non-federal share of their Medicaid and CHIP programs through general fund revenues and certified public expenditures. Puerto Rico, the U.S. Virgin Islands, and Guam primarily operate using general funds, American Samoa primarily uses certified public expenditures, and the Northern Mariana Islands uses a combination (CMS, 2016e).

Total spending

Spending in Puerto Rico accounts for nearly all the federal Medicaid and CHIP spending in the territories. In FY 2015, federal Medicaid spending in all five territories totaled $1.628 billion, with $1.522 billion (93 percent) attributable to Puerto Rico. Federal CHIP funding totaled $141.2 million, with $128.9 million (91 percent) attributable to Puerto Rico (Table 2).

TABLE 2: Medicaid and CHIP Funding and Spending in the Territories, FY 2015 (millions)

Territory	Medicaid			CHIP			Additional ACA funds under Sections 2005 and 1323[1]
	Federal ceiling	Spending		Federal allotment	Spending		
		Federal	Territory		Federal	Territory	
American Samoa	$10.9	$15.2	$11.5	$1.7	$1.7	$0.4	$197.8
Guam	16.1	47.4	35.8	5.9	5.9	2.0	292.7
Northern Mariana Islands	5.7	16.2	12.2	1.2	0.9	0.3	109.2
Puerto Rico	329.0	1,521.5	840.5	183.2	128.9	55.1	6,325.0
U.S. Virgin Islands	16.5	27.9	18.8	5.0	3.8	1.7	298.7

Source: MACPAC 2016, CMS 2016b; MACPAC 2015b.
Notes: Federal Medicaid ceilings reflect the annual ceilings for federal funds that territories receive under Section 1108(g) of the Social Security Act, while the actual federal spending reflects utilization of the additional allotments provided by the ACA, as well as spending not subject to the cap on federal financial participation. Federal CHIP allotments are provided under Section 2104 of the Social Security Act. For spending and allotments for FYs 2011–2014, see individual territory fact sheets.
[1]Includes each territory's combined portion of the funds available under Section 2005 and Section 1323. Does not reflect any utilization of these funds by the territories.

In FY 2015, federal spending for Medicaid in all five territories exceeded the annual funding ceilings. This spending reflects the use of the additional funds available under Section 2005 of the ACA. The territories have drawn these funds down at different rates. MACPAC and CMS estimate that at the current rate of spending, only Puerto Rico and the Northern Mariana Islands are likely to exhaust their funds prior to their expiration (CMS 2016e).

Data and Reporting

Like states, the territories report data on Medicaid and CHIP budget projections using Form CMS-37 and on enrollment and spending (both aggregate and by category) using Form CMS-64. The territories are not required to report expenditures beyond their federal limits, although in general, they do report all of their spending (CMS 2016e).

American Samoa and the Northern Mariana Islands are exempt from all data and reporting requirements under their Section 1902(j) waivers. Additionally, none of the territories are considered states for the purpose of required quarterly reporting of statistical and program expenditure data for CHIP (42 CFR 457.740). Due to administrative capacity constraints, American Samoa, Guam, and Puerto Rico do not report all of the same data as states even where they are not statutorily exempt. For example, CMS does not collect EPSDT service data via Form CMS-416 from any of the territories, or data on upper payment limit (UPL) payments for any of the territories except Guam (CMS 2016d).

Use of Medicaid Management Information System (MMIS) among the territories has been limited and is still developing. The U.S. Virgin Islands is the only territory with a fully operational MMIS, which it implemented in partnership with West Virginia (GAO 2015).[9] Puerto Rico is currently in the requirements phase of an MMIS project that was targeted to begin development in June 2016. Guam is also in the process of developing an MMIS (CMS 2016b). For the purposes of developing an MMIS, territories can access federal Medicaid funds that do not apply toward their ceilings at a 90 percent federal match (CMS, 2016e).

Quality Measurement and Program Integrity

Territories do not participate in many of the federally required quality and program integrity efforts that apply to states. The Northern Mariana Islands and American Samoa exempt from these requirements through their 1902(j) waivers. Puerto Rico, the U.S. Virgin Islands, and Guam are statutorily exempt from the Payment Error Rate Measurement (PERM) program, from facing repayments under the Medicaid Eligibility Quality Control program (MEQC), and are not required to implement asset verification systems with financial institutions (42 CFR 431.954; and §§1903(u)(4) and 1940(a)(4) of the Act).

While Puerto Rico, the U.S. Virgin Islands, and Guam are required to establish Medicaid Fraud Control Units (MFCUs), none of them have done so. Some territories have implemented provider screening and provisions related to non-payment for health care-acquired conditions and provider-preventable conditions. Puerto Rico, whose entire Medicaid population is enrolled in managed care, requires quality reporting in its managed care contracts (CMS 2016e).

Endnotes

[1] Residents of all territories may travel to or establish residency in any state on the mainland without restriction. However, while residing in the territory, they cannot vote in U.S. presidential elections, and do not have a voting representative in Congress. Additionally, they generally do not pay federal income taxes except on income from sources outside of their territory, including the other territories and states, if that income is over the filing threshold. Residents of the territories do pay most other federal taxes, including Medicare taxes (IRS 2016).

[2] Historically, territories were not included in the Medicaid drug rebate program but may have received territorial government-mandated price concessions and other discounts. Effective April 1, 2017, territories will be included in the Medicaid drug rebate program but may request a waiver to opt out (CMS 2016c).

[3] While all territories technically provide this benefit under the state plan, there are instances of limitations on the benefit. For example, a report by the 2011 President's Task Force on Puerto Rico's Status found that the children in Puerto Rico's Medicaid program only received limited benefits through EPSDT (Muñoz et al. 2011).

[4] Unlike the states, territories do not disburse disproportionate share hospital (DSH) payments (§1923(f)(9) of the Act).

[5] Unlike the states, the territories are not required to establish Medicare Savings Programs (§1905(p)(4)(A) of the Act).

[6] Individuals in the territories are not eligible for the Medicare Part D low-income subsidy (§1935(e)(1)(A) of the Act).

[7] With the funds from Section 1323, territories could choose to establish a health insurance exchange or supplement their available federal Medicaid funds. None of the territories chose to establish a health insurance exchange.

[8] Federal funds for the Enhanced Allotment Plan, electronic health record incentive program payments, and for the establishment and operation of eligibility systems and Medicaid Management Information Systems (MMIS) do not apply toward the ceiling.

[9] West Virginia began allowing the U.S. Virgin Islands to use its MMIS in 2013 in a first-of-its-kind partnership. While West Virginia does not charge for the use of the system, the U.S. Virgin Islands does contribute towards maintenance and operating costs, which it pays directly to the fiscal agent. This arrangement allows the U.S. Virgin Islands to avoid having to construct a system from scratch and allows West Virginia to reduce its own contribution towards maintenance and operations (GAO 2015, CMS 2016b).

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. State Medicaid and CHIP Profiles. https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. E-mail to MACPAC staff, March 23.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016c. Medicaid program; covered outpatient drugs; final rule. *Federal Register* 81, no. 20 (February 1): 5169–5357.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016d. E-mail to MACPAC staff, January 15.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016e. Telephone conversation with MACPAC staff, January 13.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Children's Health Insurance Program plan activity as of May 1, 2015. http://www.medicaid.gov/chip/downloads/chip-map.pdf.

Center for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Amendment to the American Samoa state plan. June 6, 2014. Baltimore, MD: CMS. http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AS/AS-12-004.pdf.

Central Intelligence Agency (CIA). 2015. Country comparison: Population. In *The world factbook.* https://www.cia.gov/library/publications/the-world-factbook/rankorder/2119rank.html.

Committee on Ways and Means, U.S. House of Representatives. 2014. Appendix B. *Green book: Background material and data on the programs within the jurisdiction of the Committee on Ways and Means*. Washington, DC: Committee on Ways and Means. http://greenbook.waysandmeans.house.gov/2014-green-book/appendix-b-social-welfare-programs-in-the-territories.

Internal Revenue Service (IRS). 2016. Tax Topic 901: *Is a person with income from Puerto Rico required to file U.S. federal income tax return?* June 20, 2016. Washington, DC: IRS. https://www.irs.gov/taxtopics/tc901.html.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. Exhibit 6: Federal medical assistance percentages (FMAPs) and enhanced federal medical assistance percentages (E-FMAPS) by state, FYs 2013–2017. In *MACStats: Medicaid and CHIP data book.* December 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/federal-medical-assistance-percentages-fmaps-and-enhanced-fmaps-e-fmaps-by-state-selected-periods/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. Exhibit 33: Federal CHIP allotments, FY 2014-FY 2016. In *MACStats: Medicaid and CHIP data book.* December 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/federal-chip-allotments/.

Muñoz, C., T.J. Perrelli, T. Treviño, et al. 2011. *Report by the President's task force on Puerto Rico's status.* March 11, 2011. Washington, DC: The White House. https://www.whitehouse.gov/sites/default/files/uploads/Puerto_Rico_Task_Force_Report.pdf.

U.S. Department of Health and Human Services (HHS). 2013. Assistance on the Medicaid program in Puerto Rico. In *Report to the President's task force on Puerto Rico status.* Washington, DC: HHS.

U.S. Government Accountability Office (GAO). 2015. Report to the Ranking Member, U.S. Senate Committee on Homeland Security and Governmental Affairs. *CMS supports use of program integrity system but should require states to determine effectiveness.* Report no. GAO-15-207. Washington, DC: GAO. http://gao.gov/assets/670/668233.pdf.

U.S. Government Accountability Office (GAO). 2016. *Medicaid and CHIP: Increased funding in U.S. territories merits improved program integrity efforts.* GAO-16-324. Washington, DC: GAO. http://www.gao.gov/assets/680/676438.pdf.